IN RE YAZ®, YASMIN®, OCELLA® LITIGATION	**SUPERIOR COURT OF NEW JERSEY LAW DIVISION: BERGEN COUNTY**
	CASE NO. 287
This Document Relates to All Actions	**CIVIL ACTION**

PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who used Yaz® and/or Yasmin® and/or Ocella®. Whether completing this fact sheet for yourself or for someone else, please assume that "You" means the Yaz® and/or Yasmin® and/or Ocella® user.

In filling out this form, please use the following definitions: (1) "**health care provider**" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric or psychological care or advice, and any pharmacy, weight loss center, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you; (2) "**document**" means any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone-records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

You may attach as many sheets of paper as necessary to fully answer these questions.

I. CASE INFORMATION

1. Name of person completing this form: _____

2. Please state the following for the civil action that you filed:

a. Case caption: _____

b. Docket Number: _____

c. Court in which action was originally filed: _____

d. Name, address, telephone number, fax number and email address of principal attorney representing you:

Name: _____

Firm: _____

Address: _____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____

3. If you are completing this Plaintiff Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

a. Your name:

_____

b. Current Address: _____

c. In what capacity are you representing the individual or estate: _____

d. If you were appointed as a representative by a court, state the:

Court Which Appointed You: _____

Date of Appointment: _____

_____

e. What is your relationship to the individual you represent: _____

_____

THE REST OF THIS PLAINTIFF FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO USED YAZ® AND/OR YASMIN® AND/OR OCELLA®

II. PERSONAL INFORMATION

1. Name: _____

2. Maiden or other names used and dates you used those names: _____

_____

3. Current Address and Date when you began living at this address: _____

_____

4. Identify each address at which you have resided during the last ten (10) years, and the dates you resided at each one.

Address	Dates of Residence

5. Social Security Number: _____

6. Date and Place of Birth: _____

7. Current Marital Status: _____

8. If married, has your spouse filed a loss of consortium or other claim?

   Yes _____ No _____

9. Occupation of current spouse: _____

10. Name(s) of current and former spouse(s), date(s) of marriage(s) and dates the marriage(s) were terminated, if applicable, and the nature of the termination (*e.g.*, death, divorce):

_____

_____

_____

11. If you have children, please identify each child's name, address and date of birth.

Child's Name and Address	Date of Birth

12. Identify all schools you attended, starting with high school:

Name of School	Address and Telephone Number	Dates of attendance	Degree Awarded	Major or Primary Field

13. Are you currently employed? Yes_____ No_____

If "Yes", please identify your current employer and position there: _____

_____

a. Did you ever leave this job for a medical reason? Yes_____ No_____

If "Yes", describe why you left: _____

_____

14. Have you ever served in any branch of the military? Yes _____ No _____

a. Branch and dates of service: _____

If "Yes", were you ever were discharged for any reason relating to your medical, physical or psychiatric condition?

Yes _____ No _____

If "Yes", state what that condition was: _____

b. Have you ever been rejected from military service for any reason relating to your medical, physical, or psychiatric condition?

Yes _____ No _____

If "Yes", state what that condition was: _____

_____

15. Identify each insurance carrier with whom you had health insurance coverage at any time beginning ten (l0) years prior to using Yaz® and/or Yasmin® and/or Ocella® (or the age of 13, whichever is later) up to the present, and please include all private insurance and public assistance if applicable:

Name of Insurance Company	Policy Number	Name of Policy Holder/Insured (if different than you)	Approx. Dates of Coverage

16. Have you applied for workers' compensation, social security, or state or federal disability benefits within the past ten (l0) years?

Yes _____ No _____

If "Yes", then as to each application, separately state:

a. Date (or year) of application: _____

b. Type of benefits: _____

c. Nature of claimed injury/disability: _____

d. Period of disability: _____

e. Amount awarded: _____

f. Basis of your claim: _____

g. Was claim denied? Yes_____ No_____

h. To what agency or company did you submit your application:

_____

i. Claim/docket number, if applicable:_____

17. Have you ever been denied life insurance for reasons relating to your health?

Yes_____ No_____ I don't know_____

If "Yes", please state when the denial occurred, the name of the life insurance company, and the company's reason for denial:

_____

_____

18. Have you ever filed a lawsuit other than the present suit, relating to any bodily injury within the past ten (10) years?

Yes_____ No_____

If "Yes", please explain the nature of the case, where it was filed, and identify your lawyer:

_____

_____

_____

19. In the last 10 years, have you been convicted of or pled guilty to any felony and/or have you been convicted of or pled guilty to any crime that involved an alleged act of dishonesty or providing a false statement?

Yes_____ No_____

If "Yes", please state the charge to which you pled guilty to or were convicted, as well as the court where the action was-pending: _____

_____

III. HEALTH CARE PROVIDERS AND PHARMACIES

1. Identify each doctor or other health care provider who you have seen for medical care and treatment in the past ten (10) years:

Doctor or Health care Provider's Name	Doctor or Health care Provider's Specialty	Address	Reason for Visit	Approx. Dates/Years of Visits

2. Identify each hospital, clinic, or health care facility where you were hospitalized (inpatient, out-patient, or emergency room visit) in the past ten (10) years:

Name	Address and Telephone Number	Admission Date(s)	Reason for Admission Approx dates/years of visits

3. Identify each pharmacy that has dispensed medication to you in the past ten (10) years:

Name of Pharmacy	Address and Telephone Number of Pharmacy	Name of medication dispensed	Approx. Dates/Years You Used Pharmacy

IV. MEDICAL BACKGROUND

1. Current Height:_____

2. Current Weight:_____

3. Approximate weight immediately before using Yaz® and/or Yasmin® and/or Ocella®:_____

4. Approximate weight at the time of your injury:_____

5. Approximate date and age of your first menstrual period:_____

6. **Tobacco Use History:** For the three (3) year period prior to your use of Yaz® and/or Yasmin® and/or Ocella® up to the present Check the answer and fill in the blanks applicable to your history of tobacco use, including cigarettes, cigars, pipes, and/or chewing tobacco/ snuff.

___ I have never used tobacco.

___ I used tobacco in three year period prior to my use of Yaz® and/or Yasmin® and/or Ocella®

Type(s) of tobacco used (cigarettes, cigars, pipes, smokeless tobacco, snuff)_____

Approximate Date tobacco use started: _____

Approximate Amount used: _____

___ I currently use tobacco

Type(s) of tobacco used (cigarettes, cigars, pipes, smokeless tobacco, snuff)_____

Approximate Date tobacco use started: _____

Approximate Amount currently using: on average ___ per day for __ years

___ I have used different amounts of tobacco at different times (please identify type(s) of tobacco used and dates of use below).

_____

_____

7. **Alcohol Consumption**: For the one (1) year period prior to your use of Yaz® and/or Yasmin® and/or Ocella® up to the present, did you drink alcohol (beer, wine, etc.)?

Yes _____ No _____

If "Yes", fill in the appropriate blank with the number of drinks that best represents your approximate average alcohol consumption during that time:

_____drinks per week, or

_____drinks per month; or

_____drinks per year; or

Other (describe): _____

8. **Caffeine Consumption**: For the one (1) year period prior to your use of Yaz® and/or Yasmin® and/or Ocella® up to the present, did you consume caffeinated beverages (*e.g.*, coffee, tea, soda):

Yes _____ No _____

(a) If "Yes", fill in the appropriate blank with the number of drinks that best represents your approximate average caffeine consumption during that time:

_____drinks per week, or

_____drinks per month; or

_____drinks per year; or

Other (describe): _____

(b) State the type of caffeinated beverages consumed (*e.g.*, coffee, tea, soda):

_____

_____

9. State whether in the 30 day period prior to the onset of the injuries for which recovery is sought in this action, you engaged in any prolonged travel (meaning six hours or longer), such as sitting in an airplane or a long car trip, and set forth the date of such travel, and provide a description of such prolonged travel, including date(s) and method(s) of travel:

_____

_____

_____

10. Have you ever been diagnosed with or sought treatment for any of the following conditions? Please select "Yes", "No" or "Unknown" for each condition.

(a) For each condition for which you answer "Yes", please provide the additional information requested in subpart (b):

Condition	Yes	No	Unknown
1. Abnormal genital bleeding			
2. Abnormality of blood vessels or circulatory system			
3. Acne (within one year of use of Yaz®/Yasmin®/Ocella®)			
4. Adrenal insufficiency			
5. Alcoholism			
6. Allergy, such as hay fever, asthma, eczema, hives, sensitivity to drugs and other substances			
7. An abnormal physical condition symptomatic of any disease such as edema of the extremities, pain in the extremities, prolonged (longer than 1 week) subnormal or elevated temperature, recurring headaches, jaundice			
8. Aneurysm			
9. Angina or chest pain			
10. Anorexia or bulimia			
11. Any blood clotting disorder			
12. Arteriovenous malformation (AVM)			
13. Autoimmune disease or condition such as lupus, rheumatoid arthritis, psoriasis, scleroderma, or mixed-connective tissue disorder			
14. Bleeding disorder			
15. Blood clots or thrombosis			

Condition	Yes	No	Unknown
16. Blood disorder or dyscrasia			
17. Brain tumors			
18. Cancer - Breast			
19. Cancer - Cervical			
20. Cancer - Endometrial			
21. Cancer - Other form of Cancer			
22. Cerebrovascular disease or condition			
23. Coronary artery disease or other heart disease			
24. Cystitis			
25. Deep Vein Thrombosis (DVT)			
26. Diabetes			
27. Ectopic Pregnancy			
28. Elevated Cholesterol			
29. Gastrointestinal disease such as gallbladder disease, colitis, intestinal obstruction, liver dysfunction			
30. Glandular disease, such as malfunction of the pancreas, parathyroid, thyroid, adrenal, or pituitary			
31. Gout			
32. Heart attack			
33. Heart valve disease or abnormality			
34. Hepatic dysfunction or active liver disease			
35. Hypercoagulable conditions (*e.g.*, conditions, whether genetic or acquired, in which your blood clots too much)			
36. Hypertension or high blood pressure			
37. Hypotension			
38. Increased C-reactive protein (CRP) levels			
39. Infectious disease, such as tuberculosis, pneumonia, rheumatic fever, syphilis, gonorrhea, typhoid fever, encephalitis, poliomyelitis, malaria or hepatitis			
40. Irregular heart beat, atrial fibrillation, arrhythmia, heart palpitations, tachycardia (rapid heart beat), bradycardia (slow heart beat)			
41. Jaundice			

Condition	Yes	No	Unknown
42. Kidney disease or impaired kidney function			
43. Liver tumor			
44. Migraine or other headaches with neurological symptoms			
45. Mitral valve prolapse			
46. Neurological disease or condition (such as Parkinson's disease, paralysis)			
47. Ovarian cysts			
48. Peripheral vascular disease			
49. Portal Vein Thrombosis			
50. Premenstrual dysphoric disorder (or "PMDD")			
51. Premenstrual syndrome (or "PMS")			
53. Pulmonary Embolism (PE)			
54. Retinal bleed			
55. Rheumatological condition			
56. Seizure disorder or epilepsy			
57. Shortness of breath			
58. Stroke or brain hemorrhage (any type)			
59. Transient Ischemic Attack (TIA)			
60. Varicose veins			
61. Vasculitis			

(b) For each condition for which you answered "Yes" in the previous chart, please provide the information requested below (and attach additional pages as necessary):

Condition	Approximate Date of Onset	Name, Address and Telephone Number of Treating Health Care Provider or Health Care Facility

V. ADDITIONAL MEDICATIONS

1. Do you currently take, or have you ever taken in the last ten (10) years, any of the following medications (generic name is followed brand name products in [brackets]):

Name of Medication	Yes	No	Not sure/ Unknown/ Do Not Recall
1. ACE inhibitors (*e.g.*, captopril [Capoten], enalapril maleate [Vasotec], lisinopril [Zestril] benazepril [Lotensin], fosinopril [Monopril], moexipril [Univasc], perindopril [Aceon], quinapril [Accupril], ramipril [Altace], trandolapril [Mavik])			
2. Aldosterone antagonists (*e.g.*, spironolactone [Aldactone], eplerenone [Inspra])			
3. Angiotensin-II receptor antagonists (*e.g.*, losartan [Cozaar], valsartan [Diovan], irbesartan [Avapro], candesartan [Atacand], eprosartan [Teveten], olmesartan [Benicar], telmisartan [Micardis])			
4. Antibiotics (*e.g.*, ampicillin, tetracycline, griseofulvin)			
5. Anticoagulants (*e.g.*, Coumadin, Warfarin, Fragmin, Lovenox, or Heparin)			
6. Anticonvulsants (*e.g.*, Phenobarbital, phenytoin [Dilantin], carbamazepine [Tegetrol])			
7. Any medications for migraine headaches			
8. Ascorbic acid [Vitamin C]			
9. Asthma/breathing medications			
10. Atorvastatin [Lipitor]			
11. Blood pressure medications			

Name of Medication	Yes	No	Not sure/ Unknown/ Do Not Recall
12. Diuretics			
13. Heart medications (excluding aspirin)			
14. Minocycline (*e.g.*,[Myrac, Dynacin])			
15. NSAIDs (*e.g.*, ibuprofen [Motrin, Advil], naproxen [Naprosyn, Aleve])			
16. Phenylbutazone			
17. Potassium supplement			
18. Potassium-sparing diuretics (*e.g.*, amiloride [Midamor], triamterene [Dyrenium])			
19. Rifampin [Rifadin]			
20. St. John's Wort (hypericum perforatum)			
21. Thyroid Medications			

(a) If you indicated "Yes" for any of the above medications/drugs, please provide the information requested below (and attach additional pages as necessary):

Name of Medication/Drug Used	Dates of Use (approx.)	Name, Address and Telephone Number of prescribing Health Care Provider or Health Care Facility

2. Are there any prescription medications that you have taken on a regular basis in the past ten (10) years?

Yes_____ No_____

(a) If "Yes", please for each prescription medication provide the following information:

Name of Prescription Medication Used on a Regular Basis	The health care provider(s) that Prescribed the Medication	Approximate dates/years taken	Your understanding as to why you were taking the Medication

3. For the 20 days before the onset of the injuries for which recovery is sought in this action, please identify whether you have taken/ingested any of the following:

Name of Medication/Drug/Supplement	Yes	No	Do Not Recall
1. Ephedra			
2. Prescription diet medications			
3. Cocaine/crack cocaine			
4. Attention deficit medications			
5. Heroin or methadone			

Name of Medication/Drug/Supplement	Yes	No	Do Not Recall
6. Marijuana or hashish			
7. LSD, ecstasy, ICE, PCP, MDMA			
8. Amphetamines			
9. Inhaled non-prescriptive substances (*e.g.*, glue or toluene)			
10. Caffeine pills containing stimulants (*e.g.*, No-Doz, Vivarin)			
11. Over the counter appetite suppressants			
12. Dietary supplements			
13. Herbal products			
14. Steroids			

(a) If you indicated "Yes" for any of the above medications/drugs, please provide the information requested below (and attach additional pages as necessary):

Name of Medication/Drug/Supplement	Approximate Date used (that is ***within*** 20 days of your alleged Yaz® and/or Yasmin® and/or Ocella® related injury)

4. ***Except for the medications/drugs/supplements identified in question 3 above, for the twenty (20) day period before the onset of the injuries for which recovery is sought in this action***, set forth: (a) the name of each and every over the counter and prescription drug product ingested or otherwise used by you (including all vitamins, nutritional supplements, and all herbal and homeopathic medications and remedies); (b) the date of each ingestion or use; (c) the dosage ingested and frequency of use; (d) the purpose for using each such product; (e) the prescribing physician, if any; (f) the pharmacy or store where the product was purchased; and (g) the date of purchase. Attach additional sheets as necessary.

Name of over-the-counter or prescription drug:	Date(s) of ingestion or use:	Dosage ingested or used and frequency:	Purpose of use:	Prescribing health care provider (if any):	Pharmacy or store where purchased:	Date of purchase:

VI. PREGNANCY HISTORY

1. Have you ever been pregnant? Yes_____ No _____

   a. If "Yes", state your total number of pregnancies: _____

   b. If "Yes", state your total number of live births: _____

   c. If "Yes", indicate below whether during pregnancy, you were diagnosed with or believe you experienced any of the following:

Name of Condition	Yes	No	Unknown	If "Yes", state approx. date(s)
Toxemia				
Gestational Diabetes				
Pre-eclampsia				
Miscarriages				

VII. FAMILY MEDICAL HISTORY

1. Please indicate, to the best of your knowledge, whether your parents, sibling, or grandparents have ever suffered from any of the following:

Condition	Yes	No	I Don't Know
1. Abnormality of blood vessels			
2. Aneurysm			
3. Angina or chest pain			
4. Arteriovenous malformation			
5. Autoimmune disease or condition (*e.g.*, lupus, rheumatoid arthritis, psoriasis, scleroderma, or mixed connective tissue disorder)			
6. Bleeding disorder			
7. Blood clots or thrombosis or any other blood clotting disorder			
8. Blood disorders or dyscrasias (abnormal blood cells)			
9. Brain Tumors			
10. Cancer			
11. Cerebrovascular disease or condition			
12. Deep vein thrombosis (DVT)			
13. Diabetes			
14. Elevated Cholesterol			
15. Glandular disease (such as malfunction of the pancreas, parathyroid, thyroid, adrenal or pituitary)			
16. Heart attack			
17. Heart disease			
18. Heart valve disease or abnormality			
19. Hypercoagulable conditions			
20. Hypertension or high blood pressure			
21. Hypotension			
22. Increased C-reactive protein (CRP) levels			
23. Infectious disease (within the past year, such as tuberculosis, pneumonia, rheumatic fever, typhoid fever, encephalitis, poliomyelitis, malaria, or hepatitis)			

Condition	Yes	No	I Don't Know
24. Irregular heart beat, atrial fibrillation arrhythmia, heart palpitations, tachycardia (rapid heart beat), bradycardia (slow heart beat)			
25. Migraine			
26. Mitral valve prolapse			
27. Neurological disease or condition (such as Parkinson's disease or paralysis)			
28. Peripheral vascular disease			
29. Phlebitis			
30. Portal vein thrombosis			
31. Pulmonary Embolism (PE)			
32. Retinal bleed			
33. Rheumatological condition			
34. Seizure disorder or epilepsy			
35. Stroke of any type or brain hemorrhage			
36. Transient ischemic attack (TIA)			
37. Varicose veins			
38. Vasculitis			

(a) For each condition for which you answered "Yes" in the immediately preceding chart, please provide the information requested below (and attach additional pages as necessary):

Condition	Date of Onset (approx.)	Relationship to You	Treatment and Outcome (If known)	Name and Address of Treating health care provider or health care facility (If known)

VIII. USE OF CONTRACEPTIVES OTHER THAN YAZ® AND/OR YASMIN® AND/OR OCELLA®

1. Did you use contraceptives before your use of YAZ® and/or Yasmin® and/or Ocella®?

   Yes___ No____

2. If Yes, what contraceptives have you used in the past *before* you used YAZ® and/or Yasmin® and/or Ocella®? Check all that apply below.

Form of Contraception	Yes	No	Unknown
(a) Oral contraceptives (*e.g.*,. birth control pills)			
(b) Norplant (*e.g.*,. implants under skin)			
(c) Depo-Provera® (the shot)			
(d) NuvaRing®			
(e) Transdermal contraceptives (*e.g.*, Ortho Evra®)			
(f) Intrauterine device (IUD)			
(g) Contraceptive sponge			
(h) Diaphragm			
(i) Condoms			
(j) Spermicide			
(k) Rhythm method			
(l) Other			

For each "*Yes*" you have checked above, provide the following:

Form of contraception (*i.e.*, precise name/type of product): _____
Approx length of use (*i.e.*, months/years):_____
Pharmacy where prescription was filled (if applicable):_____
Health care provider who prescribed it:_____

Form of contraception (*i.e.*, precise name/type of product): _____
Approx length of use (*i.e.*, months/years):_____
Pharmacy where prescription was filled (if applicable):_____
Health care provider who prescribed it:_____

Form of contraception (*i.e.*, precise name/type of product): _____
Approx length of use (*i.e.*, months/years):_____
Pharmacy where prescription was filled (if applicable):_____
Health care provider who prescribed it:_____

IX. YAZ® AND/OR YASMIN® AND/OR OCELLA® USE

1. Have you ever used Yaz®? Yes_____ No _____

2. Have you ever used Yasmin®? Yes_____ No _____

3. Have you ever used Ocella®? Yes_____ No _____

If "Yes", identify:

a) Date(s) of use:_____ _____

b) Provide in the chart below the name(s) and address(es) of the health care provider(s) who prescribed or provided Yaz® and/or Yasmin® and/or Ocella® to you:

Name of health care provider(s)	Address of health care provider(s)

c) Provide in the chart below the name(s) and address(es) of the pharmacy(ies) or other store(s) or location(s) from which you obtained Yaz® and/or Yasmin® and/or Ocella® (if samples were provided, see no. 5, below):

Name of Pharmacy or Other Store/Location	Address

4. Do you claim that you took Yaz® and/or Yasmin® and/or Ocella® to treat PMDD, PMS or acne?

PMDD: Yes_____ No_____

PMS: Yes_____ No_____

Acne: Yes_____ No_____

If you checked "Yes" for PMDD or PMS in the preceding questions, please state whether you saw a psychiatrist, psychologist or other mental health care provider for PMDD, PMS or the symptoms of PMDD or PMS or any psychiatric and/or psychological condition(s) relating to PMDD or PMS in the last ten (10) years:

Name of psychiatrist, psychologist or other mental health care provider	Address and Telephone	Reason for Treatment	Approx. Dates/ Years of Treatment/ Visits

5. Did you receive any samples of Yaz® and/or Yasmin® and/or Ocella®?

Yes_____ No_____ I don't recall_____

If "Yes", please state the following:

a) Who gave you the sample(s): _____

b) When were samples provided: _____

c) How many samples did you get? _____

6. Were you given any written instructions, including any prescriptions, packaging, package inserts, literature, or dosing instructions with your Yaz® and/or Yasmin® and/or Ocella®?

Yes_____ No_____ I don't recall_____

If "Yes", who gave you the instructions? _____

_____

7. Were you given any oral instructions regarding your use of Yaz® and/or Yasmin® and/or Ocella®?

Yes_____ No_____ I don't recall_____

If "Yes", who gave you the instructions? _____

_____

8. Do you have in your possession or does your attorney have the packaging from the Yaz® and/or Yasmin® and/or Ocella® you alleged to have used?

Yes_____ No_____

If "Yes", who currently has custody of the Yaz® and/or Yasmin® and/or Ocella® packaging? _____

_____

9. Do you know the lot number(s) for any of the Yaz® and/or Yasmin® and/or Ocella® you received?

Yes_____ No_____

If "Yes", what is/are the lot number(s): _____

10. Do you know the expiration date for any of the Yaz® and/or Yasmin® and/or Ocella® you received?

Yes_____ No_____

If "Yes", when is/was/were the expiration date(s): _____

11. Have you ever seen any advertisements (*e.g.*, in magazines or television commercials) for Yaz® and/or Yasmin® and/or Ocella®?

Yes_____ No_____ I don't recall_____

If "Yes," identify the advertisement or commercial, and approximately when you saw the advertisement or commercial: _____

_____

_____

_____

12. Other than through your attorneys, have you had or do you believe you have had any communication, oral or written, with any of the Defendants or their representatives (including E-mail, Text Messages, E-Minders to/from you and any of the Defendants including through websites for Yaz® and/or Yazmin® and/or Ocella® and/or signing up for an on-line program)?

Yes_____ No_____ I do not recall_____

If "Yes," set forth the date of the communication, the method of communication, the name of the representative you communicated with, and the substance of the communication between you and any representatives of the Defendants: _____

_____

_____

X. INJURIES & DAMAGES

1. Are you claiming any injury as a result of taking Yaz® and/or Yasmin® and/or Ocella®?

Yes_____ No_____

If "Yes," please describe in detail your physical injury(ies) you claim were caused as result of your use of Yaz® and/or Yasmin® and/or Ocella®:

_____

_____

_____

_____

_____

a. When did this/these injury(ies) occur?_____

_____

_____

_____

_____

b. Were there any witnesses when your injury occurred or for the period of one (1) hour before your injury occurred, and if so, please state his/her/their name(s), address(es) and his/her/their relationship to you?

_____

_____

_____

c. If you were taken to a doctor or health care facility (*e.g.*, hospital or clinic) to be treated for the injury(ies), state the name and address of the persons, police department, fire department, emergency medical workers, or ambulance company who took you to the doctor or health care facility:

Name	Address

d. Were you hospitalized for this/these injury(ies)? _____

Yes_____ No_____

If "Yes", please provide the following information:

Approximate date(s) of hospital admission	Approximate date(s) of discharge	Hospital name(s) and address(es):

2. Do you claim that your use of Yaz® and/or Yasmin® and/or Ocella® caused or aggravated any psychiatric and/or psychological condition(s)?

Yes_____ No_____

(a) If "Yes", please state the following as it pertains to your treatment of any psychiatric and/or psychological condition(s) in the last ten (10) years:

Name of psychiatrist, psychologist or other mental health care provider	Address and Telephone	Reason for Treatment	Approx. Dates/ Years of Treatment/ Visits

3. **NOTE: ANSWER THIS QUESTION ONLY** if you are alleging and claiming that you suffered a stroke or other brain injury or cognitive impairment as a result of your Yaz® and/or Yasmin® and/or Ocella® use. If so, then please answer the following:

(a) Have you been treated in the last ten (10) years for any cognitive or learning problem?

Yes_____ No_____

(b) If "Yes", please state the following as it pertains to your treatment for any cognitive or learning problem in the last ten (10) years:

Name of treatment provider	Address and Telephone	Reason for Treatment	Approx. Dates/Years of Treatment/ Visits

4. Are you making a claim for lost wages or lost earning capacity?

Yes_____ No_____

(a) If "Yes", state for the last five (5) years the Annual gross income you derived from your employment:

Year	Annual gross income

5. If you are making a claim for lost wages (or are claiming a stroke, other brain injury, or cognitive impairment) identify the following for each employer you have had in the last five (5) years:

Name and Address of Employer	Approx. Dates of Employment	Occupation/Job Title	Supervisor	Reason for Leaving

6. Have you had any communications with your health care providers, orally or in writing, about whether your condition is related to your use of Yaz® and/or Yasmin® and/or Ocella®?

Yes_____ No_____ I don't recall_____

(a) If "Yes", please identify the name, address and approximate date of communication with said health care provider:

_____

_____

7. Have you spent any money as a result of using Yaz® and/or Yasmin® and/or Ocella®?

Yes_____ No_____

(a) If "Yes", please identify and itemize all out-of-pocket expenses you have incurred:

XI. FACT WITNESSES

1. Please identify all persons who you believe possess information concerning your injury(ies) and current medical conditions, other than your health care providers, and please state their name, address and his/her/their relationship to you (attach additional pages as necessary):

Name	Address	Relationship to You

XII. DOCUMENT DEMANDS

A. AUTHORIZATIONS

1) **Health care Authorizations** – For each health care provider identified in Sections III; IV; V; VII; VIII; IX and X, please provide a completed and signed (but undated) Health care Authorization in the form attached as **Exhibit "A."**

2) **Tax Return 4506 and 4506-T IRS Forms** –

a) Only if you answered "Yes" to question X.4 in the PFS and are asserting a claim for lost wages or a reduction in lost earning capacity, please provide a completed and signed IRS Form 4506 and 4506-T attached as **Exhibit "B"** for each year identified in your answer to question X.4.

b) If you answered "No" to question X.4 in the PFS and are not asserting a wage loss claim or a reduction in lost earning capacity, you are not required to provide IRS Form 4506 / 4506-T.

3) **Authorizations for the Release of Employment Records** – If you are 1) asserting a claim for lost wages or a reduction in or lost earning capacity or 2) claiming a stroke, other brain injury, or cognitive impairment, please provide a completed and signed Employment Authorization attached as **Exhibit "C"** for each employer identified in your answer question X.5.

4) **Authorization for Release of Workers' Compensation Records** – If you answered "Yes" to question II.16 in the PFS, stating that you applied for workers' compensation within the past ten (l0) years, please provide a completed and signed (but undated) Authorization for Release of Workers' Compensation Records for each agency or company you submitted your application to in the last 10 years in the form attached as **Exhibit "D."**

5) **Authorization for Release of Disability Records** - If you answered "Yes" to question II.16 in the PFS, stating that you applied for disability within the past ten (l0) years, please provide a completed and signed (but undated) Authorization for Release for each agency or company you submitted your application to in the last 10 years in the form attached as **Exhibit "E."**

6) **Educational Records** - If you are 1) asserting a claim for lost wages or a reduction in or lost earning capacity or 2) claiming a stroke, other brain injury, or cognitive impairment, please provide a completed and signed Educational Authorization attached as **Exhibit "F"** for each educational institution for each educational institution that you listed in response to question II.12.

7) **Insurance Records Authorization**- For each company listed in your response to question II.15 in the PFS, please provide a completed and signed (but undated) Authorization for Release of Insurance Records in the form attached as **Exhibit "G".**

B. FEDERAL DISCLOSURES REQUIRED PURSUANT TO 42 U.S.C. § 1395y(b)(7) and (b)(8)

Starting on January 1, 2010, Defendants must report to the federal government certain information about every Plaintiff making a personal injury claim. Please complete the Federal Disclosure statement attached to the end of this Plaintiff Fact Sheet as **Exhibit "H".**

C. OTHER RELEVANT DOCUMENTS

Documents in your possession, including writings on paper or in electronic form (if you have any of the following materials in your custody or possession, please indicate which documents you have and attach a copy of them to this Plaintiff Fact Sheet):

1. All non-privileged documents you reviewed that assisted you in the preparation of the answers to this Plaintiff Fact Sheet. Yes_____ No_____

2. A copy of all medical records and/or documents relating to the use of Yaz® and/or Yasmin® and/or Ocella®; from any hospital or health care provider who treated you in the past 10 years and who treated you for any disease, condition or symptom referred to in any of your responses to the questions above and concerning any condition you claim is related to the use of Yaz® and/or Yasmin® and/or Ocella®, including, but not limited to, all imaging studies of any part of your body that relate in any manner to the diagnosis, treatment, care or management of your condition and the injuries alleged in your Complaint. Yes_____ No_____

3. If you have been the claimant or subject of any workers' compensation, social security or other disability proceeding, all documents relating to such proceeding. Yes_____ No_____

4. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you in connection with your use of Yaz® and/or Yasmin® and/or Ocella®. Yes_____ No_____

5. Copies of advertisements or promotions for Yaz® and/or Yasmin® and/or Ocella® and articles discussing Yaz® and/or Yasmin® and/or Ocella®. Yes_____ No_____

6. Copies of the entire packaging, including the box and label for Yaz® and/or Yasmin® and/or Ocella® (plaintiffs or their counsel must maintain the originals of the items requested in this subpart). Yes_____ No_____

7. All documents relating to your purchase of Yaz® and/or Yasmin® and/or Ocella®, including, but not limited to, receipts, prescriptions, prescription records, containers, labels, or records of purchase. Yes_____ No_____

8. All documents known to you and in your possession which mention Yaz® and/or Yasmin® and/or Ocella® or any alleged health risks or hazards related to Yaz® and/or Yasmin® and/or Ocella® in your possession at or before the time of the injury alleged in your Complaint, other than legal documents, documents provided by your attorney or documents obtained or created for the purpose of seeking legal advice or assistance. Yes_____ No_____

9. All documents in your possession or anyone acting on your behalf (not your lawyer) obtained directly or indirectly from any of the Defendants. Yes_____ No_____

10. All documents constituting any communications or correspondence between you and any representative of the Defendants. Yes_____ No_____

11. All photographs, drawing, journals, slides, videos, DVDs or any other media relating to your alleged injury, and representative photographs of your life after the incident. Yes_____ No_____

12. Copies of all documents you (and not your lawyer) obtained from any source related to Yaz® and/or Yasmin® and/or Ocella® or to the alleged effects of using Yaz® and/or Yasmin® and/or Ocella®. Yes_____ No_____

13. If you claim you have suffered a loss of earnings or earnings capacity, your federal tax returns for each of the last five (5) years or W-2s for each of the last five years. Yes_____ No_____

14. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care providers. Yes_____ No_____

15. All public statements made by or on behalf of you relating to this litigation in your possession. Yes_____ No_____

16. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable). Yes_____ No_____

17. Decedent's death certificate and autopsy report (if applicable). Yes_____ No_____

XIII. DECLARATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry, that I have supplied all the documents requested in Part XII of this Plaintiff Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the Authorizations attached to this declaration.

Date:_____ _____

Signature

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